2011 Military Health System Conference

Behavioral Health in the Patient Centered Medical Home (PCMH)

An Important Part of Meeting the Quadruple Aim and Achieving Level II & III NCQA PCMH Recognition

The Quadruple Aim: Working Together, Achieving Success

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TRICARE Management Activity

Behavioral Health in the PCMH

- Overview
  - Models of Care
  - Targeting the Quadruple Aim
  - Turning the MHS Strategic Imperative Dials
  - NCQA Level 2 & 3 Recognition
  - Funding & Current Status
  - The Way Ahead

Models of Care

- **Care Management Model**

  Typically focused on a discrete clinical problem

  - Specific pathways to systematically address how BH problems are managed in PCMH
  - PC providers & care managers share information
  - Systematic interface with the outpatient mental health clinic

Models of Care

- **Primary Care Behavioral Health Model**

  Focused on all enrolled patients

  - Embedded with PC team
  - BHPs & PCMs share patient information
  - Brings a team-based management approach
  - Helps team improve BH assessment & intervention
  - Sees patients in 15-30 minute appointments
  - Same day as well as scheduled appointment availability
  - Focuses on full range of BH & health behavior change

Models of Care

- **Blended Model**

  Focused on all enrolled patients

  - Care Manager and Embedded BHP
    - Continuity of Care
    - Stepped Care
    - Access to all enrollees to BHP in the PCMH
    - Clinical Feasibility and Efficiency
    - Implements DoD/VA guidelines

Targeting the Quadruple Aim

- ***Population Health***: Prevalence of BH Problems in PC
- ***Per Capita Cost***: Cost of Unmet Needs
- ***Experience of Care***: Better Outcomes/Satisfaction
- ***Readiness****:* Delivering the Right Care at the Right Time

Population Health: Prevalence

- 80% with BH disorder visit PC at least once a year[1]
- 50% of all BH disorders are treated in PC[2]
- 48% of the appointments for all psychotropic agents are with a non-psychiatric PC provider[3]

1. Narrow et al., Arch Gen Psychiatry. 1993;50:5-107.
2. Kessler et al., NEJM. 2006;353:2515-23.
3. Pincus et al., JAMA. 1998;279:526-531.

Population Health: Unmet BH Need

- 67% with a BH disorder do not get BH treatment[1]
- 30-50% of referrals from PC to outpatient BH clinic don't make 1st appt[2,3]
- 50% of PCMs, can only sometimes, rarely or never get high-quality behavioral health referrals for patients[4]

1. Kessler et al., NEJM. 2005;352:515-23.
2. Fisher & Ransom, Arch Intern Med. 1997;6:324-333.
3. Hoge et al., JAMA. 2006;95:1023-1032.
4. Trude & Stoddard, J Gen Intern Med. 2003;18:442-449.

Population Health: Unmet BH Need

- 20% of deployed Service members screen positive for symptoms indicative of a BH condition[1]
- 78% report a need for help, but less than 1/4 receive it[1]
- Health Care Survey of DoD Beneficiaries (2008):
  - ~40% of MHS beneficiaries report difficulties accessing BH care
  - ~70% of family members report challenges accessing urgent BH care

1. Hoge et al, NEJM. 2004; 351:13-22

Per Capita Cost: Cost of Unmet Need

- BH disorders account for ½ as many disability days as "all" physical conditions[1]
- Top 5 conditions driving overall health cost (work related productivity + medical + pharmacy cost)[2]
  - Depression
  - Obesity
  - Arthritis
  - Back/Neck Pain
  - Anxiety

1. Merikangas et al., Arch Gen Psychiatry. 2007;64:1180-1188
2. Loeppke et al., J Occup Environ Med. 2009;51:411-428.

Per Capita Cost: Lower Cost When Treated

- Medical cost ↓ 17% for those receiving BH tx[1]
  - Controls who did not get BH tx cost ↑ 12.3%
- Depression tx in PC for those with diabetes[2]
  - $896 lower total health care cost over 24 months
- Depression treatment in PC[3]
  - $3,300 lower total health care cost over 48 months

1. Chiles et al., Clinical Psychology. 1999;6:204–220.
2. Katon et al., Diabetes Care. 2006;29:265-270.
3. Unützer et al., American Journal of Managed Care 2008;14:95-100.

Per Capita Cost: Lower Cost When Treated

Examples of System Impact After Integration:

Buncombe County Health Center

<u>Decrease in Health Care Costs</u>

- All health care-overall reduction---$66 PMPM
- Mental health care reduction---$295 PMPM
- In-patient cost reduction---$1455 PMPM
- High users of health care decreased---$435 PMPM

Per Capita Cost: Lower Cost When Treated

Examples of System Impact (Cont)

Cherokee Health System

<u>After At Least 1 Primary Care Behavioral Health Visit</u>

- 28% ↓ in medical use for Medicaid patients
- 20% ↓ in medical use for commercially-insured patients
- 27% ↓ in outpatient psychiatry visits
- 34% ↓ in out patient psychotherapy sessions

<u>Cherokee Use Data vs. Other Regional Providers w/o Integration</u>

- All Lower specialist utilization
- Lower ER utilization
- Lower hospital admissions
- Lower overall costs per enrollee

Experience of Care: Better Outcomes

- Quantitative & qualitative reviews[1-4]
  - Depression[1-4]
  - Panic Disorder[1,2]
- Other Studies[5]
  - Tobacco
  - Alcohol Misuse
  - Diabetes, IBS, Primary Insomnia
  - Chronic Pain, Somatic Complaints

1. Butler et al., AHRQ Publication No. 09- E003. Rockville, MD. AHRQ. 2008.
2. Craven et al., Canadian Journal of Psychiatry. 2006;51:1S-72S.
3. Gilbody et al., British Journal of Psychiatry, 2006;189:484-493.
4. Williams et al., General Hospital Psychiatry, 2007; 29:91-116.
5. Hunter et al., Integrated Behavioral Health in Primary Care: APA, 2009.

Readiness: Identifying & Treating Problems Early

1) Screening for Depression and PTSD (R-Mil)
2) Engagement of ADSM & Family in Care
3) Assistance with Health Behavior Change

Impacting Quadruple Aim & MHS Strategic Imperatives

1) Psychological health-screening referral and engagement
2) Evidence-based care-depression & anxiety consistent with CPGs
3) Engaging patients in healthy behaviors [% advised to quit smoking]
4) Annual cost per equivalent life (PMPM)
5) Enrollee use of emergency services
6) Patient satisfaction with and access to comprehensive health care
7) PCMH staff satisfaction
8) Efforts to identify and effectively manage those at risk for suicide
9) Recapture family member BH services from purchased care

PCMH Level 2 & 3 Recognition

- 1E Patient/Family Partnership
  - Practice is concerned about the entire range of a patient's health, patient self-management support
- 1G Practice Organization
  - Train and support patient/family in self-management, self-efficacy and behavior change (e.g., weight reduction, smoking cessation, stress reduction)
- 2C Comprehensive Health Assessment
  - Practice conducts and documents a comprehensive health assessment for all patients to understand their risks and needs:

PCMH Level 2 & 3 Recognition

- 3A Guidelines for Important Conditions
  - One of the conditions must be related to unhealthy behaviors (e.g., obesity) or a mental health or substance abuse condition
- 3B Care Management
  - Assesses and supports patients in adopting health behaviors
  - Assesses and arranges or provides treatment for mental health and substance abuse problems
- 5B Referral Tracking and Follow-up
  - Practice coordinates referrals designated as important (includes mental health and substance use)

Funding and Current Status

- FY12-17 POM
  - Services requested funding for 429 BH providers to work exclusively in PCMH
  - Funding for all PCMH FY12-17 requests being evaluated
- TriService Recommendations for BH in PCMH
  - MHS PCMH Guide
  - Army PCMH OPORD
  - Navy BUMED PCMH Instruction

Way Ahead

- Draft DoD Instruction/Manual
  - Tri-Service workgroup
  - Based on TriService concurred on recommendations
- Demonstration Project
  - Have off-the-shelf products and implementation role out best practices available for each Service as funds to hire new BHP in the PCMH comes available.

Take Home Message

- It is coming
  - Funding expected to be approved
- DoD Minimum Standards
  - Some already in place by Service specific instruction
- Quadruple Aim/MHS Strategic Imperatives
  - Enhance PCMH impact

Behavioral Health in the PCMH

Questions

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